

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **PHYSICIAN CONFIRMATION OF AGREEMENT TO
PURCHASE DRUGS AND MEDICAL SUPPLIES**

(PARAMEDIC)
REFERENCE NO. 701.1

I have agreed to assume responsibility for _____ purchase of
drugs, medical devices, and controlled drugs under my medical license and DEA
registration number.

Current contact information is:

(Physician's Name - Printed)

(Address)

(Business Telephone and Cellular Phone)

(e-Mail Address)

(California Physicians & Surgeons License Number)

(Physician's Signature and Date)

Please return to:

Department of Health Services
Emergency Medical Services Agency
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670
Attn: Provider Agency Program Manager